Good Intentions Are Not Enough

The earthquake that rocked Haiti on January 12 left a wide swath of destruction, with estimates of 230,000 deaths, over 200,000 injured, and more than a million left homeless.

The disaster was compounded by the epicenter having been near the capital of Port-au-Prince, which left much of the government’s facilities and infrastructure in ruins. Similarly, the United Nations and NGOs, who would normally have a leadership role in a rescue/recovery operation, lost many of their staff members.

Into this void rushed many people willing to help on so many fronts – to rescue those trapped under buildings, bring supplies of food and water, save the lives of those who were injured, evacuate others for surgery or a better life, bury others, counsel the grieving. All came eager to help and, while much help was provided, the situation also served to remind us that good intentions are not enough.

There are many myths that surround disaster assistance, whether natural or man-made. (See page 7.)

As a result of the behaviors and attitudes around these myths, disaster assistance often becomes more difficult, despite everyone’s good intentions. Bearing in mind the reality of needs and the kinds of appropriate assistance available, plans are already underway for helping Haiti to rebuild. The US pledged $100 million in emergency aid. The United Nations and Haiti have developed a $700 million plan to start getting the country back on its feet. The plan calls for massive infrastructure repair, boosting national food production, and creating employment opportunities, all in the next 18 months. The agricultural sector is a cornerstone of the plan, as the country has suffered greatly from food shortages and deforestation.

The UN-Haiti plan also calls for decentralizing government services, as much of the population has left Port-au-Prince and fled to more rural areas. While facilities were lacking or non-existent prior to the earthquake, there will be an even greater need now. This is particularly true in the health sector. An assessment conducted by Handicapped
Dear Friends,

In the last few months, as we have witnessed the devastation in Haiti, I have often thought of Helen Keller's words and, initially, dwelled on the first part of her statement. Haiti, the poorest country in the western hemisphere, has had so much suffering in its history. Four successive hurricanes in the last couple of years compounded the problems that already existed — deforestation, unemployment, food shortages, and the issues that surround poverty — malnutrition, chronic disease, and violence.

But as I thought of the second part of the quote, I was reminded that, in the midst of all the tragedy that has occurred, there is hope. The country, with help from the international community, is planning its recovery and as former President Clinton (Special Envoy to Haiti) says, the country will be “built back better.” HVO has had a small program in Haiti, training rehabilitation technicians. A group of very dedicated physical therapy volunteers has developed a unique French-language curriculum, targeted to the community, which addresses the WHO method of community-based rehabilitation. They were in the midst of training the second class of technicians when the earthquakes struck. (Please see excerpts from their blog on page 10.) As the need for their services has been so drastically demonstrated, the students have shown an even greater commitment to their studies. It is anticipated that this program will be replicated in other areas of the country, which previously offered little in the way of rehabilitation services. HVO will continue its partnership with the Haitian people with the hope that they can overcome the suffering that has plagued their country.

But what of the “underreported” stories of suffering around the world? So many people suffer from preventable diseases, untreated trauma, no oral health care, lack of prenatal care, or inaccessibility to any health care at all. With the world-wide shortage of 4 million health care workers, so many people lack the basic healthy living conditions that many of us take for granted. So, this month, please consider shining a light on those people and helping them to overcome their suffering. Volunteer, join, donate, spread the news among your colleagues. You can be a vital part of overcoming the world’s suffering.

Sincerely,

Nancy A. Kelly, MHS
Nancy A. Kelly, MHS
Executive Director

“Although the world is full of suffering, it is full also of the overcoming of it.”

—Helen Keller
Anesthesia
Ethiopia .......................... 2-4 weeks
India ................................ 2-4 weeks
Peru .................................. 1-4 weeks
South Africa ...................... 2-4 weeks
Tanzania .......................... 3 -4 weeks
Vietnam .......................... 2-4 weeks

Dermatology
Cambodia ...................... 2-3 weeks
Costa Rica ...................... 1-2 weeks
India ...................................... 2 weeks
Palau ...................................... 2 weeks
Peru .................................. 1-4 weeks
St. Lucia .......................... 1-4 weeks
Uganda ............................. 3 -4 weeks

Hand Surgery
Honduras .............................. 1 week
Peru .................................. 1-2 weeks

Hand Surgery/Hand Therapy
Nicaragua .............................. 1 week

Hematology
Cambodia .......................... 2-4 weeks
Peru .................................. 1-4 weeks
Uganda ............................. 2-4 weeks

Internal Medicine
Cambodia .......................... 2-4 weeks
India ................................ 2-4 weeks
Peru .................................. 2-4 weeks
Uganda ............................. 2-4 weeks

Nurse Anesthesia
Bhutan ................................ 1 month
Cambodia .......................... 2-4 weeks
Ethiopia ............................. 2-4 weeks

Nursing Education
Cambodia .......................... 1 -2 weeks
India ................................ 2-4 weeks
Tanzania .......................... 3 -4 weeks
Uganda ............................. 3 -4 weeks

Oncology
Honduras ............................. 1 -4 weeks

Oral Health
Cambodia .......................... 2 weeks
Honduras ............................. 2 weeks
Laos .................................. 1-2 weeks
Peru .................................. 1-2 weeks
Rwanda ............................. 2 weeks
Tanzania .......................... 2 weeks
Vietnam .......................... 1-2 weeks

Orthopaedics
Bhutan ................................ 1 month
Cambodia .......................... 2-4 weeks
Cameroon ............................. 1 month
China ................................ 2-4 weeks
Costa Rica .......................... 1 week minimum
Malawi ............................. 1 month
Moldova ............................. 2 weeks
Mongolia ............................. 2-4 weeks
Nicaragua .......................... 2 weeks
Peru .................................. 2 week minimum
St. Lucia .......................... 2-4 weeks
Tanzania .......................... 2-4 weeks
South Africa ........................ 1 month
Tanzania .......................... 2-4 weeks
Uganda ............................. 1 month

Pediatrics
Malawi ............................. 3 months
Nicaragua ............................. 1 month
St. Lucia .......................... 2-4 weeks
Uganda ............................. 2-4 weeks

Physical Therapy
Bhutan ............................. 4 months
India ............................. 2-4 weeks
Peru .................................. 2-4 weeks
St. Lucia .......................... 2-4 weeks
Suriname .......................... 2-4 weeks
Vietnam .......................... 2-4 weeks

Special Projects
Emergency Medicine
Bhutan ................................ 1 month

Mental Health
Bhutan ............................. 3 months

Pharmacy
Uganda ............................. 1 month

Wound Management
Cambodia .......................... 1 -2 weeks
India ............................. 1-2 weeks
Peru .................................. 1-2 weeks
St Lucia ............................. 1-2 weeks

Please Note: New programs are added regularly and volunteer assignments are made on a rolling basis. For the most up-to-date information on volunteer sites and scheduling, contact the HVO Program Department: programs@hvousa.org or 202-296-0928. Visit the web site www.hvousa.org.
Physical Therapists Kay and Leavitt Honored
by Celia Pechak, PT, MPH, PhD

Dr. Elizabeth Kay, PT, PhD and Dr. Ronnie Leavitt, PT, PhD, MPH were honored by the Physical Therapy division of HVO at the American Physical Therapy Association’s Global Health Reception on February 19, 2010. They were each presented with a golden apple statuette and acknowledged for their many contributions to expanding physical therapy’s role in global health. Each was lauded for blazing the trail in her own unique way, and for demonstrating important leadership in the physical therapy profession.

Dr. Kay and Dr. Leavitt were instrumental in founding the physical therapy division in 1995. In addition, Dr. Kay is past chair of the physical therapy steering committee, past Chair of HVO Board of Directors, and has volunteered hundreds of hours in Vietnam and Uganda. Dr. Leavitt is past member of the physical therapy steering committee, past program chair for the Jamaica site, and has volunteered in Jamaica, Vietnam, and Ethiopia.

Congratulations and thank you Dr. Kay and Dr. Leavitt!

Need a Gift for Someone Special?

Tribute Gifts

It is often difficult to find the right gift for someone. One gift that is sure to please is a Tribute Gift to HVO. By giving a gift in someone’s honor, you acknowledge their importance in your life and you help support the work of HVO. Your honoree receives the satisfaction of knowing the gift you gave will help improve lives around the world through better health care. (Your gift is also environmentally friendly since there is nothing to wrap – and no “stuff” to store!)

Each honoree receives a card informing them of your gift. All gifts are also acknowledged in our newsletters and annual reports and listed as gifts “In honor of...”

I Do Foundation

For those getting married, please remember that a wonderful way to acknowledge your commitment is to register with the I Do Foundation. Designate HVO as the recipient for charitable donations and urge friends and family to contribute, in lieu of wedding presents. Further information can be found at www.IDoFoundation.org

A planned gift ensures that HVO will be able to continue to make important educational strides in the improvement of health care in developing countries.

When you write or review your will, please consider leaving HVO a charitable bequest as an investment in HVO’s future. You may bequeath a specific amount of money or a percentage of your estate. Another relatively simple option is to designate HVO as the beneficiary of a life insurance policy or the assets of a retirement plan.

If you are interested in creating a charitable bequest in your will or in discussing some other charitable aspect of your estate planning, please contact Nancy Kelly at giving@hvousa.org. If you have already made a charitable bequest, please let us know! We will honor all requests to remain anonymous.
Heckling Drivers Produces Safer Ride

The Center for Global Development published the results of a road traffic safety field experiment that was conducted on a random sample of 1,000 long-distance minibuses in Kenya. Entitled, “Heckle and Chide: Results of a Randomized Road Safety Intervention in Kenya,” the authors developed stickers that could be placed in the passenger seating area that encouraged them to speak up and voice their complaints about dangerous driving.

Independent insurance claims were studied for the treatment and control groups before and after the intervention. Claims, which were an annual 10% prior to the intervention, fell by two-thirds. Claims for injury or death fell by at least 50%. The minibus drivers, who participated voluntarily, were evaluated eight months into the survey and the results indicated that passenger heckling had contributed to their safer driving practices.

The study can be viewed at: http://www.cgdev.org/content/publications/detail/1421541/

Authors of the study are James Habyarimana and William Jack, both of Georgetown University.

Why Join Health Volunteers Overseas?

Membership in HVO allows you to:

- Support HVO’s mission of “improving the availability and quality of health care in developing countries through the training and education of local health care providers”;
- Serve as a volunteer and see HVO’s work first-hand;
- Stay connected through the biannual newsletter, “The Volunteer Connection”;
- Learn of trainings & conferences through the monthly e-news bulletin, “Net Connection”;
- Access the KnowNet, HVO’s knowledge network, which is an invaluable tool providing information on program sites, trip reports, lectures provided, etc.

If you are a member but have not yet tried out the KnowNet, please contact the HVO office, (202) 296-0928 for an access code. Please consider joining HVO and take full advantage of the many benefits available to you! Check us out online: www.hvousa.org
International found that approximately 80-90% of hospital admissions after the earthquake were orthopaedic traumas. Fractures represented 51% of the cases they found, followed by amputations at 35%. Most of the amputations were lower limb, and the majority of those were above the knee. Their assessment found that 2,000-4,000 amputations could be estimated as a result of the earthquake (either as an initial life-saving measure or, later, as secondary complications set in).

Rehabilitation services prior to the earthquake were extremely limited, so that will need to be an emphasis in the country’s recovery. Another sobering finding from Handicapped International (HI) was that among those severely injured, the percentage was unusually high for those people of working age (18 – 59). HI reported that the age group represented 49% of Haiti’s population yet they noted 65% of those severely injured were from that age group. This means that with so many injured among people in their prime working years, significant efforts will need to be made to return them to work, and to make new construction accessible.

With so much to be done, recovery for Haiti will be a long process. However, in the midst of all the devastation and sorrow, there is hope for a brighter future. HVO Volunteer Denise English, PT, was training rehabilitation technicians at the Hôpital Albert Schweitzer (located 60 miles from Port-au-Prince) when the earthquake struck.
Volunteer Perspectives

MYTHS AND REALITIES OF DISASTER ASSISTANCE

Myths and Realities of Disaster Assistance

Any kind of international assistance is needed and desired immediately. Damage and needs assessments are done in the immediate hours after a disaster; it is best to wait until the needs have been determined. Unnecessary international assistance only adds to the confusion and sense of chaos, as teams often siphon off necessary transportation, fuel, and logistical and translation services.

All kinds of medical personnel are needed immediately. Often, local personnel can handle the immediate needs but as they grow fatigued or specialized personnel are required, international teams have often already departed.

Donations of blankets, clothing, and shoes are needed. The costs of packing, storing, and shipping such items is usually quite prohibitive, and often exceed the value of the goods. If they are sent abroad, there are often problems of clearing customs, as well as high costs of storage and distribution. NGOs and government organizations that work in disaster assistance usually have regional warehouses with items that are pre-packed, clean, and ready to be transported to nearby areas.

Cash donations won’t make it to the disaster area. Reputable agencies send 80% or more of cash donations to the disaster site; the rest is invested in monitoring, reporting and other activities that facilitate transparency and efficiency in their operations. Cash donations are also vital in rebuilding the local economy by purchasing appropriate items locally or in the general region.

Mass vaccinations are necessary. Mass vaccination campaigns during disaster situations are not necessary and, on the contrary, deflect resources, leaving more urgent needs unattended. (Resuming basic, routine vaccination schedules as soon as possible is recommended, however, so the re-emergence of diseases does not occur.)

Dead bodies, left unburied, are a dangerous source of disease epidemics after disasters. The bodies of disaster victims pose little or no threat to public health.

Burying victims quickly in mass graves gives survivors a sense of relief. It is very important for survivors to have a chance to identify their loved ones and grieve for them in a culturally-appropriate way.

The affected population is too shocked and defenseless to take responsibility for its own survival. People often show great resilience in an emergency. Their skills and management capacity must be considered when developing support programs, because those can be key factors in a successful recovery.

Unaccompanied children should be quickly adopted to remove them from dangerous conditions. While it is crucial for children to be protected, it is important that they be with members of their community, that family members be located, and that the children can begin to deal with the disaster in appropriate ways.

Life returns to normal in a few weeks. The effects of a disaster last a long time. Countries deplete much of their financial and material resources in the immediate post-impact phase. Donor fatigue often occurs as needs and shortages become more pressing. Successful relief operations must consider that funds and support will be necessary through different phases of the emergency until the population is able to recover its livelihood.

Natural disasters cause deaths at random. Disasters cause more damage to vulnerable geographic areas, and vulnerable groups which live in situations of inequity and poverty. Such groups include women, children, those with disabilities, and the elderly. Often, these people survive the disaster itself, only to become seriously ill or die as a result of not receiving necessary care.

Insurance and governments can cover losses. The vast majority of the world’s population has never heard of an insurance policy.

Sources:
- Pan American Health Organization’s Be a Better Donor: Practical Recommendations for Humanitarian Aid
- U.S. Agency for International Development
- World Vision Relief Director Edward Brown in The Medical News
Reflections from the Field

*Linda Baumann, PhD, RN and Dory Blobner RN, MS, CDE*

*Nursing Education – Uganda*

This trip to Uganda was an example of how long-term relationships with local health professionals and volunteers who learn and listen to their needs can come together to result in a synergistic experience for both parties. We were able to bring added value to the ongoing work in diabetes care and training being done by the physicians and nurses at Mulago Hospital and the staff at the nursing school of Makerere University. In all it was a satisfying visit, leaving us with many ideas for future directions in collaborative work.

*Mark J. Carlson, MD – Orthopaedics – Cambodia*

The weekly schedule consisted of a clinic on Wednesdays after rounds and a teaching conference. I presented talks during both weeks I was there. I emailed Dr. Phot in advance and he suggested the topics. I spoke on fractures around the knee and ankle fractures over the two weeks. It's important to keep talks basic and straightforward. The residents are eager to learn but they can become lost pretty quickly. Also, twenty to thirty minutes is plenty for the talk and the rest for questions. Wednesday ortho clinic is usually for follow up and evaluation of new patients. There is a lot of neglected trauma with patients usually treated initially by a traditional healer. Amputations are done pretty commonly for diabetic problems and inoperable extremity problems, such as TB, chondrosarcoma, or old compartment syndrome with disabling contractures.

*Peter Curran, MD – Internal Medicine – India*

I spoke 1-3 times a day, and found that reviews of recent literature and reviews of published care guidelines seemed especially well-received. I also met with the residents 3 times to review board questions which seemed to go over well...I felt this to be a very positive experience on several levels and would recommend it.

*Jamie Cheung, MD – Anesthesia – Tanzania*

Each day, we started by attending morning report, during which the students presented the pre-ops for that day’s cases. If appropriate, we would also make small teaching points or discuss our experience with particular clinical matters. Then we would split the students into two groups. While one group was in the theaters, we lectured the other group in a small hallway adjacent to the theaters. We tried to pick smaller topics for our morning lectures, but with questions and further explanations on related subjects, these lectures usually lasted for at least an hour each. After we finished lecturing the first group, we would send them to the theater and then proceed to give the same lecture to the other half of the students. We often went into the theaters to talk to students about various practical topics, or just observe them clinically. Then in the afternoon, we would give a lecture to the entire class. These lectures usually lasted about an hour, but again often went over time secondary to questions. About once a week, we tried to do a review session about previous topics.

The teaching role is perfect. With morning report, at least three hours of giving lectures a day, and trying to visit the operating rooms, I do not think we could have had time to do anything more. I also feel like this was the best use of our time; doing strictly clinical work would only benefit a few patients. Teaching will hopefully help the nurse anesthetists provide better care during their time at Bugando Medical Center, as well as during their permanent positions all across Tanzania in less than a year’s time.

In summary, this trip was probably one of the greatest experiences of my medical life. It is one thing to be cognizant of the vast diversity of health care quality and resources available; it is a completely different thing to be able to see it all first-hand. It was so immensely enjoyable and rewarding to teach students who are so eager to learn, and who have such a paucity of education otherwise. I would go again in a heartbeat.
**Ted Sussman, MD – Internal Medicine – Cambodia**

The hospital routine remains the same. I start in the ER with a 30-45 minute lecture at 7:30 am. Topics are generally clinical subjects that may have been discussed the day before. I stress proper history and physical diagnosis as trainee doctors are prone to short cuts. These are usual whiteboard talks but PowerPoint presentations on a laptop work as well. Handouts are always welcome but all PowerPoints can be left on a server in the medical department (a zip drive is also frequently passed around). After this I would attend in the ER until ward round at 10:30. However this year I frequently would walk over to the outpatient medical clinic where many of the same problems would be seen. Attending in the medical clinic is also useful if another volunteer is available in the ER. Since I do echos I would also take patients over for imaging to give trainees immediate feedback on their physical diagnosis or assessments.

Ward round finished the morning, in which the 12 bed inpatient medical unit is rounded upon by me, one or two trainee doctors, and usually I junior doctor. The senior doctor on the ward would also attend although I not infrequently might attend alone depending on circumstances. In any case, the senior doctor responsible for the ward always maintained ultimate responsibility over the staff. Attendings from the Institute for Tropical Medicine in Belgium were frequently also present and both nurses and pharmacy rounded with us.

After lunch, attending in the ER or medical clinic resumed until a 3:30 pm formal lecture based upon the internal medicine curriculum that they have established. This year I gave talks on COPD, asthma, sleep apnea and noninvasive ventilation (I had brought over a BiPAP machine). In addition other talks such as infective endocarditis and EKG interpretation were also given. The day usually ended at the hospital around 4:30.

**Lynn Sloane Bemiller, MD, FACP – Hematology – Peru**

Where I feel I was most helpful was in the area of laboratory evaluation of thrombotic disorders. I spent time reviewing the hospital’s capabilities and procedures for coagulation and coagulopathy testing. Based on their current practices, I worked with the director of the hematology laboratory to design a standard format for thrombophilia testing. Once staff are comfortable with the idea of guidelines, this could be expanded into a standardized order set for testing and inpatient anticoagulation. Ultimately, I would envision the hospital system using standardized guidelines for the better management of outpatients on oral anticoagulation. Accepting standardization will require some culture change on the part of many physicians, but I can foresee a role for future volunteers in the development of subsequent guidelines.
Volunteer Perspectives

BLOG ENTRIES FROM HAITI – DENISE ENGLISH, PT

Blog Entries from Haiti – Denise English, PT

Denise English, PT, and Chuck Gulas, PT, PhD, GCS were volunteering in Haiti when the earthquake struck. The following is adapted from blog entries Denise posted, as well as her thoughts, which are in italics.

NEWS FROM DESCHAPELLES AND REHABILITATION AT HAS

We arrived, Chuck Gulas and I, on January 4, 2010. The trip up from Port-au-Prince to Deschapelles went smoothly.

Beginning the second Rehabilitation Technician Training Program at Hôpital Albert Schweitzer (HAS), brought us back. Class started on January 6, 2010. We found ourselves sharing knowledge and laughter with our six delightful students – each one different – each one engaging – each one expressing their desire to become part of the health care community assisting the disabled. They are pioneers. Rehabilitation in this country is in its infancy.

► I became aware of the floor beginning to move under my feet - it was subtle at first - the realization that it was likely an earthquake took a few seconds. Shortly the aftershocks began. After it had settled down I e-mailed my family. My daughter Erin e-mailed back that it was being announced in the media. I was surprised that such a huge earthquake was being reported. The quake here was not nearly as violent. We had no reason to suspect what was happening in Port-au-Prince.

► Slowly word of what was happening in Port-au-Prince began to come in. Telephone service was gone but e-mail remained, although spotty. Before dawn on Wednesday patients began arriving by transport from Port-au-Prince. Most medical facilities in Port-au-Prince were rendered inoperable. Hôpital Albert Schweitzer was one of the few operating without interruption, having been spared the damage of the earthquake. It was a key rescue facility.

Patients began arriving at HAS before dawn on Wednesday, January 13. We’d felt the quake late in the afternoon Tuesday, and the aftershocks continued into the next day. We experienced more of them over the next several weeks.

Most medical facilities in Port-au-Prince were rendered inoperable. Hôpital Albert Schweitzer was one of the few operating without interruption, having been spared the damage of the earthquake. It was a key rescue facility.

Wednesday continued to see the arrival of vehicle after vehicle of the injured from Port-au-Prince. We are 70 miles by road from the capital.

Our classroom at the hospital was turned over for patient care. The Physiotherapy room cleared out and functioned as a ward.
We held class that day (and every day that followed) at our house. The day began with discussion of news the students had received. The day ended with laughter. A good decision to spend the day together. A sense of purpose in a situation that was full of uncertainty.

The days after the quake were quite somber. The students each knew someone who was affected. Phone service began to return with news of family and friends. Some good. Some devastating.

Chuck and I were privileged to witness the initial mobilization of the hospital staff and community members in response to the arrival of the injured. A sense of calm – in the midst of suffering – prevailed. Patients were carried in the doors – often in the arms of security staff and other hospital employees called into action. Community members came to assist. The nurses moved quietly between patients. Soon it appeared that every possible place was filled. Hallways were impassable at times.

The patients continued to arrive through the night Wednesday and were still coming late Thursday night when I returned to the house around 11:00. There was not as much heart-wrenching wailing that evening. Now we were spilling out into the courtyards. The halls had long ago been filled to capacity – and then some. The injuries were sobering – fractures, spinal cord and head injuries, amputations.

Families filled the area surrounding the hospital looking for members that they hope have been brought here – there is a sense of cooperation and respect. There has been frequent mournful wailing – and there is the quiet singing of hymns in the wards.

For our part, we assisted wherever we were needed. Helping to transfer patients. Position them. Splinting fractures until they could be reduced – eventually going to cardboard and cloth wrapping. The suffering was at times almost unbearable.

We moved then to mobilizing patients. We worked alongside our newly graduated rehabilitation technicians. When we left on January 24 patients were still arriving in a steady stream.

We remarked that when we are in the midst of this we feel hopeful. We experienced the power of a simple gesture in a powerless situation – holding a hand, a nod of acknowledgement, listening. I have had the chance to communicate intimately with people who are strangers – and in a moment are not strangers anymore.

We were certain, more than ever, that the training of rehabilitation workers here will impact the lives of many that they touch. It already has. While the circumstances are harsh, the responses have been calm and determined. The hospital has begun conserving resources in anticipation of the long recovery that will follow.

It’s been four weeks today since everything changed. So many things for the worse. Some, as a result, for the better. Infrastructure is being created. Groups are working in concert rather than isolation. Rehabilitation is now being pushed front and center.

► The first few days we did anything that needed to be done. Helping to move injured people once they had been evaluated by the physicians, looking for wheelchairs or carts or doors to use to transport patients who needed to be taken to x-ray or surgery, clearing out rooms for the quickly overflowing patient population, relaying messages. As patients become stable they are referred for physical therapy. David Charles, PT, the Director of Rehabilitation Services here at HAS, (recently hired from Port-au-Prince and university-trained in the Dominican Republic) moved amongst the patients and assisted the physicians and nurses. The injuries are extensive and severe. Amputations, burns, head, spinal cord and crush injuries. Often in combination.

Adapted from early blog entries - Friends of Hôpital Albert Schweitzer www.friendsofhas.org Additional blog entries describe other early and ongoing events there as patients begin their healing and rehabilitation.
...to the following individuals and companies who have so generously donated teaching materials, equipment, supplies, and other support:

Ambu, Inc.
American Society for Surgery of the Hand
AmeriCares
Covidien
Daniel Fried
Krista Hendricks, MD
Hinesight Surgical Services, Inc.
International Federation of Societies for Hand Therapy
Journal of Bone and Joint Surgery
Kimberly-Clark Global Sales, LLC
MAP International
MedFix Solutions, Inc.
Medtronic
Minneapolis Cardiology Association
New England Journal of Medicine
Osteotech, Inc.
Salter Labs
Scanlan International
Smith & Nephew Endoscopy
Smiths Medical
Stryker Instruments
Synthes, Inc.
Justin Wendling

...to the following donors for their generous financial support

Salma Abdu, DDS
Oluchide Ajayi, MD
Cathy Alcock
Ann Alexander, MD
Richard Alpert
Anchorage Fracture & Orthopaedic Clinic
Gilbert Anderson, MD
Henry Anderson
Jessica Anderson
Frank Andolino, DDS
Anonymous
Raymond Attridge
Will Augustenhaugh, MD
Arthur Bababekov
Patricia Bachiller, MD
Asha Bajaj, PT, DPT

Marshall Balk, MD
Brani Barr, MD
Ted Barr
Linda Baumann, PhD, RN, CS
Paul Baxt, MD
J. Robert Beatty
David Beauchamp, MD
Lynn Bemiller, MD
Pamela Benson
Richard Bernstein
Trung Bien
Cesar Blanco
Terrell Blodgett
Robert Blotter, MD
George Bogumill, MD
William Bohl, MD
Albert & Elaine Borchard Foundation
Yves Boudreau, MD
Evelyn Boyd
Heather Broman
John Brown
William Brown, DDS
Robert Bucholz, MD
Miguel Cabanela, MD
Chris Cahn
Juan Camargo
Lamont Cardon, MD
Mattiuoi Catchpole, CRNA, PhD
Maureen & Larry Cavaiola
Kathryn Cerabona
Earl & Margery Chapman Foundation
Lynette Charity
Gurmeeet Cheema
Konnie Chen
Stanley Clark, MD
James Cobey, MD, MPH
Laurence Cohen, MD
Arnold Cohn, MD
James Cole, MD
Jessica Collins
Joanne Conroy, MD
Brian Costello
Jay Cox, MD
Larry Crook, MD
Peter & Bonni Curran - PECO Foundation
Saundra Curry, MD
Emily Cutting, DPT
Gayle Davis
Thomas Degenehardt, MD
Robert Derkash, MD
Jeffrey Diercksmeier
Lisa Dobberteen
Karen Domino, MD
Douglas Donnelly
Denise Dowd, MD, MPH
Mary Dudley, CRNA, MS
Thomas Dunn, DDS
Jane Easdown, MD
Tina Marie Eddy, RN
Steven Eisenberg
Heather Eller
S. Christopher Ellis, MD
Denise English, PT
Dale Erickson, MD, FACP
Sue Alice Erickson, RN, MS, PhD
James Ertle, MD
Jack Eskenazi
Alex Etemad, MD
Kevin Etkorn
Frederick Falharzadeh, MD
Andy Fecteau, PT, MS
Rita Feinberg
Valerie Ferguson
Karen Fernandez, MD
Margaret Fletcher, PT
David Frost, DDS, MS
Marshall Gallant, DMD
Dennis Gates, MD
Richard Geer, RN
James Gerry
Robert Gibson, MD
Givingexpress Program-American Express
Christina Gill
Global Giving
L. Michael Glode, MD
Davina Gohil
Rita Golub
Elaine Goodall, PT, MEd
Lisa Goodman
Dennis Graham, DO
Stuart Grant
Nancy & Gordon Green
Jeff Greenberg, MD, MS
Megan Gridley
Lynne Grieco
Marian Griffiths, MD
R. Michael Gross, MD
Bryan Gunnue, MD
Jason Guzik
Edward Habermann, MD & Susan Koehn Foundation
Kerry Hall
Margaret Hanna, CRNA
Leslie Hardy, MHS
Brian Harrington, MD
Hill Hastings, MD
Heather Hayden
Arthur Hazlewood, DDS, MPH
Lore Heath, CRNA, MSN
Nader Hебela, MD
Richard Henker, PhD, RN, CRNA
Theresa Hennessey, MD
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Abiodun Ijaola
Brad Ireland
Mary Isham, MD
Seiji Itahara
Floyd Jaggears
Marlene Jagou, DPT
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